DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: Physical Therapists
Managed Care Plans

Memorandum No: 04-48 MAA
Issued: June 14, 2004

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration (MAA)

For Information Call:
1-800-562-6188

Supersedes: **03-45MAA, 03-79MAA**

Subject: Physical Therapy Program: Fee Schedule Changes

Effective for dates of service on and after July 1, 2004, the Medical Assistance Administration (MAA) will implement:

- The updated Medicare Physician Fee Schedule Data Base (MPFSDB) Year 2004 relative value units (RVUs); and
- The Year 2004 additions of Current Procedural Terminology (CPT™) codes.

Maximum Allowable Fees

MAA is updating the Physical Therapy Program fee schedule with Year 2004 RVUs. The maximum allowable fees have been adjusted to reflect these changes. The 2004 Washington State Legislature **did not appropriate a vendor rate increase** for the 2005 state fiscal year.

New CPT Code

Assistive technology assessment (CPT code 97755) has been added to the tests and measurements procedures allowed in the physical therapy program. It is considered part of the physical therapy program 48-unit limitation.

Attached are updated replacement pages 9/10, 12a/12b, and 13-16 for MAA's Physical Therapy Program Billing Instructions, dated May 2000. **Note: Pages 9, 12a, and 16 have no changes. We are including these pages because they are attached to the back or front of the changed pages.** To obtain MAA's numbered memoranda and billing instructions electronically, go to MAA's website at http://maa.dshs.wa.gov (click on the Provider Publications/Fee Schedules link).

Bill MAA your usual and customary charge.

Additional Coverage **(Client 21 years of age and older)**

MAA covers a maximum of 96 physical therapy program units in addition to the original 48 units only when billed with one of the following diagnoses:

- **Principal** diagnosis codes:

Diagnosis Codes	Condition
315.3-315.9, 317-319	For medically necessary conditions for developmentally delayed clients
343 - 343.9	Cerebral palsy
741.9	Meningomyelocele
758.0	Down's syndrome
781.2-781.3	Symptoms involving nervous and musculoskeletal systems, lack of coordination
800-829.1	Surgeries involving extremities-Fractures
851-854.1	Intracranial injuries
880-887.7	Surgeries involving extremities-Open wounds with tendon involvement
941-949.5	Burns
950-957.9, 959-959.9	Traumatic injuries

-OR-

- A completed/approved inpatient Acute Physical Medicine & Rehabilitation (Acute PM&R) when the client no longer needs nursing services but continues to require specialized outpatient therapy for:

854	Traumatic Brain Injury (TBI)
900.82, 344.0, 344.1	Spinal Cord Injury, (Paraplegia & Quadriplegia)
436	Recent or recurrent stroke
340	Restoration of the levels of function due to secondary illness or loss for, Multiple Sclerosis (MS)
335.20	Amyotrophic Lateral Sclerosis (ALS)
343 - 343.9	Cerebral Palsy (CP)
357.0	Acute infective polyneuritis (Guillain-Barre syndrome)
941.4, 941.5, 942.4, 942.5, 943.4, 943.5, 944.4, 944.5, 945.4, 945.5, 946.4, 946.5	Extensive Severe Burns
707.0 & 344.0	Skin Flaps for Sacral Decubitus for Quads only
890-897.7, 887.6-887.7	Open wound of lower limb, Bilateral Limb Loss

Physical Therapy Program Limitations

Duplicate services for Occupational, Physical, and Speech therapy are not allowed for the same client when both providers are performing the same or similar procedure(s). [WAC 388-545-500 (11)]

Note: A program unit is based on the CPT code description. For CPT codes that are timed, each 15 minutes equals one unit. If the description does not include time, the procedure equals one unit regardless of how long the procedure takes.

If time is included in the CPT code description, the beginning and end times of each therapy modality must be documented in the client's medical record.

The following are considered part of the physical therapy program 48-unit limitation:

- Application of a modality to one or more areas not requiring direct patient contact (CPT codes 97010-97028);
- Application of a modality to one or more areas requiring direct patient contact (CPT codes 97032-97039);
- Therapeutic exercises (CPT codes 97110-97139);
- Manual therapy (CPT code 97140);
- Therapeutic procedures (CPT code 97150);
- Prosthetic training (CPT code 97520);
- Therapeutic activities (CPT code 97530)
- Self care/home management training (CPT code 97535);
- Community/work reintegration training (CPT code 97537); and
- Physical performance test or measurement (CPT code 97750). Do not use this code to bill for an evaluation (CPT code 97001) or re-evaluation (CPT code 97002).
- Assistive technology assessment (CPT code 97755)

Expedited Prior Authorization (EPA)

The EPA process is designed to eliminate the need for written authorization. The intent is to establish authorization criteria and identify these criteria with specific codes, enabling providers to create an "EPA" number when appropriate.

To bill MAA for diagnoses, procedures and services that meet the EPA criteria on the following pages, the provider must **create a 9-digit EPA number**. The first six digits of the EPA number must be **870000**. The last 3 digits must be the code number of the diagnostic condition, procedure, or service that meets the EPA criteria. Enter the EPA number on the billing form in the authorization number field, or in the *Authorization* or *Comments* field when billing electronically.

Example: The 9-digit authorization number for additional physical therapy units for a client who has used 48 PT units this calendar year and subsequently has had knee surgery, would be **870000640** (**870000** = first six digits of all expedited prior authorization numbers, **640** = last three digits of an EPA number indicating the service and which criteria the case meets).

Expedited Prior Authorization Guidelines

A. Diagnoses

Only diagnostic information obtained from the hospital or outpatient chart may be used to meet conditions for EPA. Claims submitted without the appropriate diagnosis, procedure code or service as indicated by the last three digits of the EPA number will be denied.

B. Documentation

The billing provider must have documentation of how expedited criteria was met, and have this information in the client's file available to MAA on request.

Washington State
Expedited Prior Authorization Criteria Coding List
For Physical Therapy(PT) LEs

PHYSICAL THERAPY

CPT: 97010-97150, 97520-97537, 97750, 97755

Code	Criteria
640	**An additional 48 Physical Therapy program units** when the client has already used the allowed program units for the current year and has one of the following surgeries or injuries: 1. Lower Extremity Joint Surgery 2. CVA not requiring acute inpatient rehabilitation 3. Spine surgery
641	**An additional 96 Physical Therapy program units** when the client has already used the allowed program units for the current year and has recently completed an acute inpatient rehabilitation stay.

Are school medical services covered?

MAA covers physical therapy services provided in a school setting for school-contracted services that are noted in the client's Individual Education Program (IEP) or Individualized Family Service Plan (IFSP). Refer to MAA's School Medical Services Billing Instructions. (See *Important Contacts*.)

What is not covered? [WAC 388-545-500(12)(13)]

- MAA does not cover physical therapy services that are included as part of the reimbursement for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.

- MAA does not cover physical therapy services performed by a physical therapist in an outpatient hospital setting when the physical therapist is not employed by the hospital. Reimbursement for services must be arranged through the hospital.

Fee Schedule

Note: A program unit is based on the CPT® code description. For CPT codes that are timed, each 15 minutes equals one unit. If the description does not include time, the procedure equals one unit regardless of how long the procedure takes.

Due to its licensing agreement with the American Medical Association, MAA publishes only official, brief CPT code descriptions. To view the full descriptions, please refer to your current CPT book.

Procedure Code	Brief Description	July 1, 2004 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
Tens Application			
64550	Apply neurostimulator	11.11	5.44
Muscle Testing (The maximum allowable is for payment in full, regardless of time required.)			
95831	Limb muscle testing, manual	14.28	9.52
95832	Muscle testing manual	12.47	9.52
95833	Body muscle testing, manual	21.08	16.10
95834	Body muscle testing, manual	25.39	20.40
95851	Range of motion measurements	12.24	5.67
95852	Range of motion measurements	8.61	3.85
Modalities			
97010	Hot or cold packs therapy	Bundled	
97012	Mechanical traction therapy	9.07	9.07
97014	Electrical stimulation therapy	8.61	8.61
97016	Vasopneumatic device therapy	8.61	8.61

Procedure Code	Brief Description	July 1, 2004 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
97018	Paraffin bath therapy	4.08	4.08
97020	Microwave therapy	2.95	2.95
97022	Whirlpool therapy	9.07	9.07
97024	Diathermy treatment	3.63	3.63
97026	Infrared therapy	2.95	2.95
97028	Ultraviolet therapy	3.63	3.63
(For the procedures listed below, the therapy provider is required to be in constant attendance.)			
97032	Electrical stimulation	9.52	9.52
97033	Electrical current therapy	12.70	12.70
97034	Contrast bath therapy	8.61	8.61
97035	Ultrasound therapy	7.48	7.48
97036	Hydrotherapy	14.06	14.06
97039	Physical therapy treatment	7.03	7.03
Therapeutic Procedures (Therapy provider is required to be in constant attendance.)			
97110	Therapeutic exercises	17.46	17.46
97112	Neuromuscular re-education	17.46	17.46
97113	Aquatic therapy/exercises	19.95	19.95
97116	Gait training therapy	14.96	14.96
97124	Massage therapy	13.38	13.38
97139	Physical medicine procedure	9.52	9.52
97140	Manual therapy	16.10	16.10
97150	Group therapeutic procedures	10.65	10.65

Procedure Code	Brief Description	July 1, 2004 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
97504	Orthotic training	18.59	18.59
97520	Prosthetic training	17.00	17.00
97530	Therapeutic activities	17.68	17.68
97535	Self care mngment training	18.14	18.14
97537	Community/work reintegration	16.55	16.55
97542	Wheelchair mngment training	Not Covered	
97545	Work hardening	Not Covered	
97546	Work hardening add-on	Not Covered	
97601	Wound care selective	23.58	23.58
97602	Wound care non-selective	19.50	19.50
Tests and Measurements			
97001	Pt evaluation	45.11	38.77
97002	Pt re-evaluation	23.80	19.50
97703	Prosthetic checkout	15.42	15.42
97005	Athletic evaluation	Not Covered	
97006	Athletic re-evaluation	Not Covered	
97750	Physical performance test	17.46	17.46
97755	Assistive technology assessment	21.08	21.08
Other Procedures			
97532	Cognitive skills development	Not Covered	
97533	Sensory integration	Not Covered	
97799	Unlisted physical medicine rehabilitation service or procedure	By Report	

Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

- MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- The provider must submit claims as described in MAA's billing instructions.

- MAA requires providers to obtain an ICN for an initial claim within 365 days from any of the following:

  - ✓ The date the provider furnishes the service to the eligible client;
  - ✓ The date a final fair hearing decision is entered that impacts the particular claim;
  - ✓ The date a court orders MAA to cover the services; or
  - ✓ The date DSHS certifies a client eligible under delayed[1] certification criteria.

- MAA may grant exceptions to the 365 day time limit for initial claims when billing delays are caused by either of the following:

  - ✓ DSHS certification of a client for a retroactive[2] period; or
  - ✓ The provider proves to MAA's satisfaction that there are other extenuating circumstances.

- MAA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.

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[1] **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider MUST refund any payment(s) received from the client for the period he/she is determined to be medical assistance-eligible, and then bill MAA for those services.

[2] **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found eligible for the medical service at the time he or she received the service. The provider MAY refund payment made by the client and then bill MAA for the service.